SKIN SURGERY CENTER OF VIRGINIA

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HIPAA Omnibus Notice of Privacy Practices

Effective Date: April 1, 2015 | Revised: March 30, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information (PHI). "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

1. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION We may use and disclose your PHI in the following situations:

Treatment: We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

Payment: Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

Health Care Operations: We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Minors: Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

Required by Law: We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

Abuse, Neglect, and Domestic Violence: Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

Judicial and Administrative Proceedings: As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

Law Enforcement: We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

Coroners and Medical Examiners: We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

Public Health: Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

Health Oversight Activities: We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

Inmates: If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

Military, National Security, and other Specialized Government Functions: If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials

Immunizations: We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

Worker's Compensation: We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

Practice Ownership Change: If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

Breach Notification Purposes: If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

Research: Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

Business Associates: We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

2. USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

Communication with family and/or individuals involved in your care or payment of your care: Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

Disaster: In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

Fundraising: As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

3. USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

Disclosure of Psychotherapy Notes: Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

Disclosures for marketing purposes and sale of your Protected Health Information.

4. PROTECTED HEALTH INFORMATION AND YOUR RIGHTS The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

You have the right to inspect and copy your Protected Health Information (reasonable fees may apply): Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

You have a right to a summary or explanation of your Protected Health Information: You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

You have the right to obtain an electronic copy of medical records: You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

You have the right to receive a notice of breach: In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

You have the right to request Amendments: At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

You have a right to receive an accounting of certain disclosures: You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

You have the right to request restrictions of your Protected Health Information: You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

You have a right to request to receive confidential communications: You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

You have a right to receive a paper copy of this notice: Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

5. CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice, will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. We will not retaliate against you for filing a complaint.

6. COMPLAINTS

If you believe your privacy rights have been violated and you'd like to register a complaint, you may do so with us or the Secretary of the United States Department of Health & Human Services.

HIPAA Compliance Officer:	2510 Gaskins Road Henrico, VA 23238	**US Department of Health & Human Services:**	**The Joint Commission:**
Mark Rausch, MD, HIPAA Compliance Officer	Email: info@mohsvirginia.com	Website: www.hhs.gov/ocr/hipaa/	E-mail: patientsafetyreport@jointcommission.org
Christine S. Rausch MD, PC	Phone: 804.282.4940	Phone: 202.619.0257	Fax: 630-792-5636

7. ACKNOWLEDGMENT

I acknowledge that I have been given the opportunity to review the HIPAA Notice of Privacy Practices and that may ask to speak with the HIPAA Compliance Officer in person or by phone at the number listed above, should I have question or concerns regarding this document. I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that the scanned document is the same as the original.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Relationship to Patient

Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices (NPP) provides information about how Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC may use and disclose protected health information (PHI). As specified in the NPP, Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC intends to use and disclose the minimum necessary PHI about you for treatment, payment or health care operation purposes. I understand that at any time I many ask questions to Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC if I do not understand any information contained in the NPP.

I, _____, have had the opportunity to review the Notice of Privacy Practice for Christine S. Rausch MD, PC / Skin Surgery Center of Virginia, LLC and I was offered and;

_____ INITIAL I ***received*** a copy of the Notice of Privacy Practices (NPP)

_____ INITIAL I ***declined*** a personal copy of the Notice of Privacy Practices (NPP)

I, _____, have had the opportunity to review the Patient Bill of Rights, Advance Directive and Physician Ownership and I was offered and;

_____ INITIAL I ***received*** a copy of the Patient Bill of Rights, Advance Directive and Physician Ownership

_____ INITIAL I ***declined*** a personal copy of the Patient Bill of Rights, Advance Directive and Physician Ownership

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our office and copies are available at any time.

Communication of Protected Health Information (PHI)

For Biopsy and / or Medical Results:

My preferred method of contact is (please choose all that apply):

☐ Email to this address (non-encrypted):_____

☐ Voice mail message at this phone number: _____

☐ Written letter to my mailing address on file: _____

For Financial Information:

You may contact me at this phone number: _____

You may leave a message at the phone number listed above: [ ] Yes [ ] No

Authorization Form for Use & Disclosure of Protected Health Information

It has been explained to me that disclosures of Personal Health Information (PHI) may be made to family and friends in accordance with my instructions below. It has also been explained that only information relevant to current treatment will be disclosed. Accordingly, I authorize the disclosure of health care information to (list all that apply):

Name	Relationship	In Person	By Phone	OK to leave Message	Phone Number

I acknowledge that Christine S. Rausch, MD PC / Skin Surgery Center of Virginia, LLC will scan this document and destroy the original, and agree that scanned document is the same as the original.

_____ Signature of Patient or Responsible Party

_____ Date

_____ Printed Name of Signature

_____ Relationship to Patient